HIGHMARK. HEALTH OPTIONS

Private Duty Nursing (PDN) Prior Authorization Request Form

Complete and fax all requested information below including any supporting documentation as applicable to Highmark Health Options at **1-855-445-4239**. **Authorization is based on medical necessity. Incomplete information or illegible forms will delay processing.**

Questions or concerns? Call Utilization Management at 1-844-325-6251, Monday through Friday, 8 a.m. to 5 p.m.

Date: _____

Member Information		
Member Name	**Member ID**	**Date of Birth**
Caregiver Name	**Caregiver Phone**	
Diagnosis	**ICD-10 Code**	**HCPCS Code**

Type of Request	
Initial PDN Request? ☐ Yes ☐ No	**Annual PDN Review?** ☐ Yes ☐ No
Change in Medical Condition or Needs? ☐ Yes ☐ No	**If other, explain:**
Is the member currently or recently hospitalized? ☐ Yes ☐ No	**Discharge Date**

Indicate if the PDN hours are requested for:		
Work ☐ Yes ☐ No	**School or Daycare** ☐ Yes ☐ No	**Sleep** ☐ Yes ☐ No

Indicate Days Per Week and Number of Hours Per Day the PDN Services are Requested	
☐ **Sunday**	**Number of hours per day requested:** _____
☐ **Monday**	**Number of hours per day requested:** _____
☐ **Tuesday**	**Number of hours per day requested:** _____
☐ **Wednesday**	**Number of hours per day requested:** _____
☐ **Thursday**	**Number of hours per day requested:** _____
☐ **Friday**	**Number of hours per day requested:** _____
☐ **Saturday**	**Number of hours per day requested:** _____
☐ **Non-School Days (i.e, inservices, closures)**	**Number of hours per day requested:** _____

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Required Past Medical History (Attach additional documentation as needed)

Current Medications (Attach supplemental sheet if necessary)			
Medication	**Route**	**Frequency**	**Dosage**

PDN and Skilled Nursing Needs
Describe the activities of PDN and skilled nursing provided during the hours requested.

Supporting Clinical Information

Seizures	
Seizures ☐ Yes ☐ No	**Average Number of Seizures per Day**
Average Seizure Duration	**Interventions (e.g., VNS, Diastat, Oxygen, etc.)**
Date of Last Seizure and Interventions Used	

Cardiac and Circulatory Issues		
Cardiac and Circulatory Issues ☐ Yes ☐ No	**IV Catheter** ☐ Yes ☐ No	**Type** ☐ Broviac ☐ PICC ☐ Peripheral
Frequency of Use		

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Gastrointestinal Issues

Enteral Feeding ☐ Yes ☐ No	**Bolus Feeds** ☐ Yes ☐ No Frequency:
Continuous Feeds ☐ Yes ☐ No	**P.O. Feeds** ☐ Yes ☐ No Frequency:
Gastrostomy Tube ☐ Yes ☐ No Frequency:	**TPN** ☐ Yes ☐ No Frequency: Duration:

Respiratory Issues

Tracheostomy or Other Artificial Airway ☐ Yes ☐ No		**Ventilator** ☐ Yes ☐ No	
Ventilator Settings			
Hours per Day on Ventilator	**Which Hours**	☐ **Continuous**	☐ **Sleep Only**
Weaning Schedule			
Most Recent Recorded Oxygen Saturation Level and Date Recorded			
Oxygen ☐ Yes ☐ No ☐ Continuous ☐ Intermittent ☐ PRN		**Pulse Ox** ☐ Yes ☐ No	

Integumentary Issues

Wound Care (incl. dressing changes) ☐ Yes ☐ No Frequency:	**Ostomy Care** ☐ Yes ☐ No

Additional Information

Provide any additional information and documentation to support member's requested hours.

Services Requested for School and School Bus Transportation

This section requires accompanying documents to support the request. Include the following documents:

- A copy of this member's current Individualized Education Plan (IEP).
- School calendar for the current school year.
- Bus schedule with drop-off and pickup times, if applicable.

Name of School	
Name of School Nurse	**Phone**

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If possible, explain member's required PDN needs while in transport or school that cannot be met by services provided by transportation or school.

Caregiver Information

List all responsible caregivers in the home. Briefly describe caregiver and caregiver work, school, and medical conditions that limit the availability and duration of the caregiver to care for the member. Include backup caregiver information.
Please submit all that apply regarding caregiver's availability: • **Submit work verification from caregiver's employer noting what hours the caregiver is expected to work.** • **Submit documentation from caregiver's school registrar's office verifying enrollment and class schedule.** • **Submit documentation from caregiver's doctor outlining caregiver's disability, including prognosis and expected duration of the limitation.**

Signature and Attestation

Ordering Provider Name	**NPI Number**
Facility/Practice Name	
Provider Address	
Provider Phone:	**Provider Fax**
I hereby attest the information included in this document is true, accurate, and complete to the best of my knowledge. Additionally, I deem that the services requested are medically necessary. (Parental requests can be considered in making medical necessity determinations, however, this request is made under your signature and is similar in nature to a prescription for medication; your professional judgment for the need of a prescription medication is not predicated on patients' requests but medical need. In addition, requests that are in excess of that which are medically necessary are subject to Centers for Medicare & Medicaid Services' fraud, waste, and abuse policies and could carry associated penalties).	
Provider Signature	**Date**